Summary of LIHP Questions and Answers

LIHP Provider Handbook: http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/LIHPProviderHandbook1.pdf
LIHP Formulary: http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/LIHPDrugFormulary.pdf
LIHP Medical Policies: http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/LIHPMedicalPolicies.pdf
Provider On-line Verification for eligibility: www.sdcmspov.com
ACCESS: pubassist.HHSA@sdcounty.ca.gov
LIHP Enrollee Handbook (English): http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/LIHPEnrolleeHandbook.pdf
LIHP Enrollee Handbook (Spanish): http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/LIHPEnrolleeHandbookSPAN.pdf

6/28/11 Release			
		Input/Question	**Clarification/Answer**
1.	Agenda items	Could you add to the agenda for clinic and stakeholder meetings any surveys or contract amendments that are being sent out? It would be nice to get a heads up on those things and allow room for discussion.	Yes.
2.	Anasazi	Do primary care providers need to use the Anasazi system or chart the way the behavioral health providers, do or can they do a soap note in their own chart?	No. Only County Mental Health and contracted County Mental Health clinics will be using Anasazi. FQHC primary care and mental health clinics will continue charting and billing services as they currently do.
3.	Anasazi	Will primary care providers have access to the Anasazi system to view and/or print information on their patients? If not, how will primary care providers exchange information with mental health providers?	No. Primary care and mental health providers may exchange information in any format that protects patient confidentiality and is HIPAA compliant. County to address questions about future IT system.
4.	Anasazi	Can Contractor's submit LIHP/MCE claims to ASO directly from Anasazi?	No. Contractors will not be able to submit LIHP/MCE claims to ASO directly from Anasazi. The process for claiming is in the LIHP Provider Handbook.
5.	Application Assistance	Page 4.2, Section 4 Clinic responsibilities listed are labor intensive for clinics. If LIHP contract does not include	Assisting with applications is a requirement for participating in LIHP and receiving the LIHP rate for services.

		CAA staff resources, how will this staff time be reimbursed?	
6.	Application Assistance	a) Please further define the role of eligibility assistors? b) Will they be required to complete citizenship verification? c) How will this be submitted to the County to reduce duplication?	a) Please refer to LIHP Provider Handbook for application assistance functions. b) Verification of citizenship is not required, but is helpful. c) Documentation should be mailed to the County.
7.	Application Assistance	Page 4.2, Section 4 Is this a new expense and new activities for clinics?	Some clinics utilize application assistance activities within their organizations. For others this may be a new activity.
8.	Application Assistance	If we want to proactively work with our existing patients to help them switch from CMS to LIHP, would it be possible to: • Get a list of patients that are due for renewal each month • Have blank applications that we could assist the clients in completing • Have an expedited submittal process for apps that were completed with clinic CAA help, as opposed to those that the patients did on their own (should require less work/review from County)	No. Yes. The County cannot accommodate this at this time.
9.	Application Assistance	Page 4.2, Section 4 Although this section is only in reference to clinics, there is no similar language for hospitals in Section 6	Application assistance is currently provided through the HOS hospitals and is covered in the HOS Policies & Procedures. Non-HOS hospitals do not provide upfront application assistance.
10.	Application Assistance	Page 4.2, Section 4 Hospitals want to reiterate their concern about telling patients they might have to sign a lien, if the patient is applying for LIHP	It is unclear why hospitals feel they are required to advise patients of liens; liens are not mentioned in the LIHP Provider Handbook.
11.	Billing	What subunit/code do you use for a client that you think will be a LIHP/MCE client pending authorization from AmeriChoice which could	Mental health providers are to enter the LIHP/MCE SubUnits and Service Codes into Anasazi. The LIHP/MCE SubUnits and Service Codes were to be

		take a few days per the LIHP handbook. TAR pending vs eligibility pending	distributed prior to July 1.
12.	Billing	Can a mental health specialty site decide NOT to bill a visit?	This is at the clinic's discretion.
13.	Claims	Pg 13.1, Section 13 Again, all the providers are lumped together which creates some confusion. Hospitals request the DELETION of these requirements for claims submission: • Social Security Number • Full itemization of charges, including drugs and supplies provided All documentation and attachments required by Medi-Cal • Catalogue page or invoice when submitting an unlisted or "miscellaneous" code	The hospital billing process has not changed. Clarification will be added to the next LIHP Provider Handbook revision that the LIHP Enrollee ID number can be used in lieu of the SSN. If hospitals do not bill with an SSN or Enrollee ID #, it will cause an error on the ASO side, which will delay the process. The hospitals will need to continue billing itemized charges for hospital outpatient claims since they are not paid a per diem for these services. Hospital inpatient billing process will remain the same and continue at per diem or flat rate.
14.	Claims	Pg 13.1, Section 13 Hospitals request the following revisions: (last bullet on page) Be submitted within 30 days from the date of services **or date of discharge** to the current ASO	Suggested language will be added to the next LIHP Provider Handbook revision.
15.	Claims	Pg 13.1, Section 13 Last bullet. Claims submission within 30 days from the date of service. Is that consistent with current process and industry standards? Current CMS contract states 30 days but no later than Jul 31. See Page 13.4 which does state no later than July 31. Please add this language here to avoid confusion. Medi-Cal allows 1 year.	Please refer to updated LIHP Provider Handbook. Claims submissions are requested within 30 days from the date of service.
16.	Claims	Page 13.3, Section 13	The County of San Diego LIHP program has

		Notification of Changes to Provider Information. Last paragraph. MFT is listed. Should MFTs be included? MFTs are not eligible providers under FQHC-PPS guidelines.	included licensed MFTs as network LIHP mental health providers in its submission to the state.
17.	Claims	Page 13.4, Section 13 Appeals within a 30 day period is challenging, we recommend a minimum 45 day period to appeal. Hospitals need 120 days to resubmit the claim after receiving the denial notification.	The Appeals time frame is due to our need to monitor expenses related to implementing a cap for LIHP. We have a fiscal cap that we have to manage and therefore, we are requesting 30 day limit to appeals.
18.	Claims	Pg 13.4, Section 13 The LIHP fiscal year ends on June 30 of each year. All claims for services provided to patients certified by or referred to LIHP in a fiscal year, must be submitted to the ASO by July 31, regardless of authorization or eligibility status. What should hospitals do if a patient becomes eligible retroactively?	Answer pending, the County is researching this.
19.	Claims	How will the provider claim the services to the ASO?	The ASO prefers the electronic claiming process utilizing an 837 format but that is not required. The ASO will work with programs to ensure all the elements that are needed for billing are clear.
20.	Claims	Will there be a method to test the electronic claiming process?	Providers interested in electronic claiming should work with the ASO to determine if this is an option.
21.	Clinic Hours	Change in Hours- do we have to notify the county of all minor schedule changes or only when the hours go below 35 hours a week? Minor schedule adjustments happen frequently and this could present an administrative burden.	Notification is required if the clinic's operating hours fall below 35 hours a week.
22.	Coding	How will visits to a non-medical home site be coded/processed for billing when the reason is one of the two allowable exemptions (urgent need, primary care provider at other site)?	There will be no separate coding for these visits. Intermitted audits performed by the ASO will be used to demonstrate compliance with this requirement.
23.	Comparison of	Please clarify the difference in eligibility, services	• Eligibility comparison was provided on 6-28-11

	Programs	and reimbursement with CMS, CI and LIHP.	per this FAQ request. • Services are pending State approval, therefore we cannot provide a comparison document at this time. • Reimbursement comparison cannot be generically prepared. Each provider should refer to their Exhibit C of their corresponding contract(s).
24.	Compliance Requirements	Audit Reports- A.4, 6a- language is far too broad. County does not have legal right to access/audit reports from all other clinic programs. Please redefine to reasonable scope. Corrective action plan should be limited to those related to LIHP.	Yes, corrective action plans are limited to non-compliance with LIHP requirements.
25.	Cultural Competency	Attachment D.1 – D.3 The LIHP STCs apply to San Diego County only (in SD County managed care entity is County) Hospitals are already legally required to provide language access services—this seems unnecessary and confusing. The LIHP handbook should not seek to change current requirements—should only refer to state or federal law. Legal requirements apply to all patients, not just LIHP.	These guidelines are required by LIHP. This policy is specific to LIHP, therefore appropriate for the LIHP Provider Handbook.
26.	Cultural Competency	Attachment D.3 Add TDD phone number.	It has been added. Please refer to updated LIHP Provider Handbook, Attachment D.
27.	Cultural Competency	Page 15.1, Section 15 Primary Care Medical Home – Last bullet on interpretation services. Please clarify who pays for translation services.	The County pays for translation services.. Please refer to updated LIHP Provider Handbook, Section 3 & Attachment D.
28.	Cultural Competency	Attachment A.1 Cultural/Linguistic Competency and Translation – Culturally competent service delivery including translation 24/7 for clinic site threshold	Please refer to updated LIHP Provider Handbook, Attachment A, Page A2.

		languages. Need to define threshold languages. Is 24/7 access to translation services feasible? Is this consistent with current process and industry standards? Please clarify.	
29.	Death of an Enrollee	Pg 13.4, Section 13 Death of an Enrollee Providers are required to report the death of a LIHP enrollee to the ASO when the provider becomes aware that the LIHP enrollee has died. Hospitals are not willing to take responsibility for this.	Revised language will be added to the next LIHP Provider Handbook revision.
30.	Dental	Seems like dental benefits are decreasing from the current CI program dental benefits. If a CI patient is in the middle of a treatment plan and the CI program is ending, what is the process to complete treatment for the patient under LIHP?	Any LIHP enrollee who was in the middle of a treatment plan before July 1 and has received authorizations for services still pending (as part of the same dental treatment plan) may continue the authorized treatment as long as all treatment is completed by October 1, 2011.
31.	Dental	Can you please clarify the dental benefits? The description says that only urgent care is covered, but then states that all urgent care requires a TAR. Do all dental procedures require a TAR?	Please see Dental Policy contained in the LIHP Medical Policies. TARs are not required for the first 3 visits for a single emergency dental condition. A TAR must be approved for all subsequent visits for the same emergency dental condition. Only those procedures and codes described in the Dental Policy are covered benefits of the LIHP.
32.	Designated Care Coordinator	Page 4.2, Section 4 Is Designated Care Coordination Responsibility per site or per organization?	There must be a designated care coordinator for each site. If the same person can fulfill these duties at multiple sites, that is acceptable.
33.	Designated Care Coordinator	A Care Coordinator is required. Does this person need to be designated or dedicated?	The Care Coordinator for County and Contracted Mental Health providers will be “designated”.
34.	Designated Care Coordinator	Pg 7.1, Section 7 Hospitals request the following edits and clarifications:	No change needed, as “Primary Care Provider” is named in the title of this section.

		Each **Primary Care Provider** shall formally designate one staff member who is primarily responsible for coordinating enrollees' health care services.	
35.	Designated Care Coordinator	What will the MH Designated Care Coordinator need to know about the client?	Refer to Provider handbook, Section 5.
36.	Double Boarded Physicians	How will visits with a double boarded physician (Family Practice and Psychiatry) be counted? As a primary care visit or as a mental health visit?	If these visits are conducted at a FQHC's Specialty Mental Health clinic, then these visits will be counted as part of the 12 specialty mental health visits. If these visits are conducted within a FQHC's primary care clinic, then they are counted as a primary care visit.
37.	Due Process	Pg B.1 Hospitals request the following edits/clarifications: Additional Enrollee Rights • Provider Selection In accordance with 42 CFR 438.6, providers are reminded that LIHP enrollees have the right to obtain a list of LIHP providers **from the LIHP program (County or ASO) or their PCMH,** including information on their location, type of services offered, and areas of cultural and linguistic competence. • Second Opinion A LIHP enrollee may request a second opinion. A second opinion provides the enrollee with an opportunity to receive additional input on his or her health care. The enrollee makes their request for a second opinion to their **PCMH** provider. In turn, the medical primary care provider submits a Treatment Authorization Request to the ASO for approval.	• Revised language will be added to the next LIHP Provider Handbook revision. • The designation "PCMH" will not be added because both primary care providers and specialists may submit a TAR for a second opinion.

38.	Due Process	Attachment B.5 Administrative Review If the provider and ASO cannot successfully resolve the enrollee's grievance or appeal, the ASO will issue a finding, to be sent to the enrollee and provider, which may include the need for a Plan of Correction to be submitted by the provider to the ASO Medical Director or designee within 10 days of receipt. In the rare instances when the provider disagrees with the disposition of the grievance and/or does not agree to write a Plan of Correction, the provider may write to the ASO Medical Director or designee within 10 days, requesting an administrative review. The" ASO Medical Director or designee shall have the final decision about needed action. If needed, administrative review of the grievance will be conducted by the governing body of the LIHP Quality Management Unit. Discussion needed on this section. ASO must work within guidelines of hospital's policies and procedures regarding grievances.	The State policy regarding Due Process is final. Answer pending, the County is researching this.
39.	Due Process	Attachment B.11 Request adding the following data requirement: Reason for denial Also request that ASO provide the reports required in LIHP Handbook to HASD&IC (or publish online in AuthMed) on a quarterly basis.	County will take this under consideration. Due process policy addresses both eligibility and services. AuthMed does not contain service denial information.
40.	Eligibility/Enrollment	Page 2.1, Section 2 a) Are any fees associated with this? b) What if they are determined ineligible?	a) No. There is no cost sharing or co-payments required for LIHP program. b) Applicants will be evaluated for Medi-Cal, LIHP

			and CMS unless otherwise requested.
41.	Eligibility/Enrollment	Page 2.2, Section 2 Retroactive Coverage. Is this similar to current contract and process?	No. This does not relate to the contract. This is an eligibility process similar to Medi-Cal.
42.	Eligibility/Enrollment	Page 2.2 Section 2 If a hospital assists in applying for an individual will the hospital be notified when that patient becomes enrolled so that the hospital can bill for services provided in the retroactive months?	No. Network providers should confirm eligibility via the Provider Online Verification (POV) site or by contacting ACCESS at 1-866-262-9881, or pubassist.HHSA@sdcounty.ca.gov.
43.	Eligibility/Enrollment	Can you explain the enrollment and annual re-enrollment processes?	Individual contacts ASO at 800-587-8118 to schedule an eligibility or re-enrollment appointment. The individual completes an application at the appointment or brings a completed application and appropriate verifications to the appointment. County staff completes eligibility evaluation of applicant.
44.	Eligibility/Enrollment	Please clarify eligibility and enrollment roles and responsibilities. What is the clinic responsible for and what is the County responsible for?	Clinics will identify potential applicants and provide assistance in completing the application process. County staff will continue to retain responsibility for eligibility determination and enrollment to the program.
45.	Eligibility/Enrollment	Will FQHC staff be able to certify the citizenship documents? If so, how can we simplify/streamline the process so that we reduce County staff work and help expedite enrollment?	Deficit Reduction Act of 2005 allows for this.
46.	Eligibility/Enrollment	If you are looking at an online enrollment, I am assuming it is ok for us to set up computer stations in our clinics to help patients enroll?	On line enrollment is not currently available.
47.	Eligibility/Enrollment	If a 19 yr old living with parents wants to apply for benefits, will we request the parent's income/info before we certify for LIHP?	Pending clarification from the State.
48.	Eligibility/Enrollment	Will staff assisting with enrollment be able to use electronic verification of birth certificates?	At this time, State approved electronic verification of citizenship is available only to County eligibility staff.
49.	Eligibility/Enrollment	Can eligibility appointments occur at the	The plan is to try to provide eligibility appointments

		Contracted MH clinics?	in the most efficient manner possible. If it is feasible there will be appointments available at the Contracted MH clinics
50.	Eligibility/Enrollment	How will providers know if a client has been enrolled in LIHP/MCE?	Network providers can verify eligibility via the POV site (www.sdcmspov.com) for enrollees enrolled after January 2011. Non-network providers need to contact ACCESS to verify eligibility (1-866-262-9881, or pubassist.HHSA@sdcounty.ca.gov).
51.	Eligibility/Enrollment	Can a healthy person get LIHP coverage?	Yes
52.	Eligibility/Enrollment	Can an LIHP beneficiary have Other Health coverage?	Only LIHP MCE beneficiaries can have other health coverage.
53.	Eligibility/Enrollment	Can an applicant choose just to apply for LIHP and not CMS at initial app? According to the hospitals most individuals do not want to sign any liens (no concurrent eval desired).	Staff conducts concurrent evaluations for LIHP and CMS so that if an applicant is not eligible for LIHP, there is no delay in the CMS evaluation. The agency is currently looking at improving the process to focus on the LIHP application process.
54.	Eligibility/Enrollment	Can LIHP beneficiaries go back and forth between CMS and LIHP?	Enrollment into LIHP or CMS is dependent upon eligibility determination when beneficiary reapplies/recertifies for coverage.
55.	Eligibility/Enrollment	For clients' who are deemed "incompetent", do hospitals follow the same Medi-Cal Protocol?	Yes. For eligibility enrollment purposes, LIHP follows the Medi-Cal process for incompetent patients.
56.	Enrollee Cards	How will patients identify themselves? What's on the ID card?	The CMS cards say CMS, the CI cards say CI, the LIHP cards will say LIHP – all the acronyms are spelled out. All CI enrollees will become LIHP, so they can use the CI card for LIHP as long as they are still enrolled.
57.	Formulary/Pharmacy	Page 3.2, Section 3 Non-formulary prescription medications. Please clarify process.	The directions for obtaining non-formulary prescriptions are detailed in the instruction section of the LIHP formulary.
58.	Formulary/Pharmacy	Page 4.3, Section 4 Pharmacy Services. Please clarify reimbursement process for medications.	Pharmacy Services are reimbursed through the Pharmacy Benefit Manager (PBM), which negotiates rates with each LIHP contracted

			pharmacy.
59.	Formulary/Pharmacy	Page 9.1, Section 9 Medications are non-formulary if a Patient Assistance Program (PAP) is available. It is the responsibility of the prescribing physician to submit the PAP. Many clinic sites, especially primary care sites, do not do PAP forms due to the time and labor involved in the process.	Clarification will be added to the next LIHP Provider Handbook revision, Sections 4 & 9.
60.	Formulary/Pharmacy	In the manual, it states that physicians are responsible for submitting the Patient Assistance Application. This is commonly done by support staff. Can you switch this language to clinic rather than physicians?	Revised language will be added to the next LIHP Provider Handbook revision.
61.	Formulary/Pharmacy	What is the formulary for mental health medications?	This information is available and a link is noted in the handbook. http://www.sdcounty.ca.gov/hhsa/programs/ssp/documents/LIHPDrugFormulary.pdf
62.	Hospital Based Services	Page 1.2, Section 1 How will this work for clinics with hospitalist visits? Can the hospital get the prior authorization and the clinic bill for the admit with it? Or will the clinic need to get prior authorization from the hospital? Unclear on follow up visits in the hospital. Are these included in the authorization? Please clarify.	A direct hospital admission (ie, to admit an enrollee to a hospital bed from a clinic site without traveling through the Emergency Department) does not require prior authorization from the ASO as long as it is for an acute diagnosis or condition (e.g. not planned or pre-scheduled). This will be considered an emergency hospital admission, just as an admission where the enrollee travels through the Emergency Department to a hospital bed for an acute diagnosis or condition. Hospital bed days will be evaluated by the ASO to ensure they meet medical necessity criteria for inpatient services. One follow up visit (not including any lab or radiology testing) after discharge from the hospital with a physician who cared for the enrollee while hospitalized does not require authorization. This

			"post discharge" visit is conducted in an outpatient setting by the physician who cared for the enrollee while hospitalized.
63.	Hospital Based Services	Pg 6.1, Section 6 LIHP network hospitals are required to notify the ASO within one business day of every admission of a LIHP (or potential LIHP) enrollee. Hospitals may not know if patients are LIHP eligible within one business day. Patients do not even become eligible for inpatient services until they have been admitted to a hospital for 24 hours or more. Hospitals request that the one business day requirement be removed.	POV site should be checked for eligibility status as soon as possible after a patient has been admitted and notification made to the ASO within 1 business day of LIHP's eligibles and known pending LIHP enrollee.
64.	Hospital Based Services	Pg 6.1-6.2, Section 6 LIHP network emergency departments are required to notify the ASO within one business day of admitting a LIHP (or potential LIHP) individual into the Emergency Department. Requiring notification for "potential LIHP" individuals would result in hospitals notifying the ASO of every self-pay patient. This would be a violation of patient privacy (HIPPA). Until hospitals have determined patients are potentially eligible and WANT to apply, the hospitals cannot provide any notification to the ASO. Hospitals cannot legally meet this requirement and request that it be removed.	LIHP Provider Handbook revised "potential LIHP" to "known pending".
65.	Hospital Based Services	Pg 6.1-6.2, Section 6 The hospital & ED must send a copy of the enrollee's discharge summary and discharge instructions to the primary care site as specified	LIHP Provider Handbook Section 6 has been revised. Until a County electronic health information exchange system becomes available, hospitals are encouraged to fax discharge summaries within 14

		on the enrollee's verification of eligibility within 24 hours of discharge This requirement is not included in the State Special Terms & Conditions and would place an undue administrative burden on hospitals. Under Title 22, physicians have 14 days from discharge to complete a medical record that includes dictation of the discharge summary. LIHP Handbook provides no guidance directive on method of information transfer or what to do if the patient does not, will not or cannot identify a primary care site. The language stipulates a 24 hour turnaround, so this would even be expected on weekends and holidays. This is not required by Optum Managed Medi-Cal or the majority of other health plans. In some hospitals, Medical Staff Bylaws, Rules and Regulations define the amount of time physicians have after discharge to complete the discharge summary (14 days for example).	days to the enrollee's designated primary care site as specified on the enrollee's verification of eligibility.
66.	Hospital Based Services	Pg 6.1, Section 6 When is the authorization number provided? Is it given at the time of emergency authorization for mental health admissions?	Reference to the authorization number has been removed.
67.	Hospital Based Services	Pg 6.1, Section 6 Will there be concurrent review for ALL inpatient admissions? When would retrospective reviews be done?	There is concurrent review of all inpatient admissions for which we are notified after the 5th hospital day. There is retrospective review on those for whom we weren't notified (i.e., weren't LIHP pending at the time of admission and/or census wasn't sent to us) if they met a high cost report or if they were hospitalized for 7 or more days.
68.	Hospital Based Services	Pg 6.1, Section 6	Clarification has been added to LIHP Provider

		This language is unclear and could be interpreted as requiring hospitals to pay physicians, although they bill separately. Post-operative care is not defined. REMOVE: "Post-operative care associated with the procedure is deemed global and is not separately reimbursed." Possible alternative language: Professional services provided for a surgical admission will be included in the global reimbursement for these services if applicable and based on industry standards. Facility services will be separately billed and reimbursed.	Handbook Section 6, Inpatient Services Post-operative language removed from LIHP Provider Handbook, Section 6, Enrollee Follow-up After Hospital Discharge (formerly Inpatient Follow-up).
69.	Hospital Based Services	Pg 6.1, Section 6 Suggested revised language to clarify that payments for hospitals and physicians are separate: Payment for services includes coverage for the specialty physicians providing care in a network emergency department **but professional and facility services will be billed separately and reimbursed according to the terms of the contract.**	Suggest language will be added to the next LIHP Provider Handbook revision.
70.	Hospital Based Services	Pg 6.2, Section 6 The definition of an emergency condition needs to be based on the prudent lay person definition of emergency care.	Special Terms & Conditions definition will be added to the next LIHP Provider Handbook revision, Section 15.
71.	Hospital Based Services	Pg 6.2, Section 6 Hospitals request the following edits: a) The individual must be certified LIHP eligible	a) No, individual must be determined eligible, not

		for the date of service **or deemed eligible retroactively.** b) The condition must be **based on** the LIHP Scope of Services	deemed eligible and 3 months retroactive would be covered by a "certified for date of service". b) No, must be within LIHP Scope of Services.
72.	Hospital Based Services	6.2, Section 6 Request the edits below in bold Out-of-network providers must, as a condition for receiving payment for emergency services, notify the LIHP program within 24 hours or **next business day** of admitting the patient to the hospital from the emergency room, and, with respect to post-stabilization care, meet the approval protocols established by the LIHP program **and the requirements set forth under California Health and Safety Code Section 1371.4.**	This is STC language (63f.ii), therefore we will leave language as is.
73.	LIHP Handbook	How often will updates to LIHP Provider Handbook be done?	The handbook will be updated as needed and as appropriate.
74.	LIHP Handbook	Will there be an LIHP Beneficiary Handbook?	Yes, there is an English and Spanish version. They can be located at: http://www.sdcounty.ca.gov/hhsa/programs/ssp/low_income_health_program/index.html
75.	LIHP Handbook	Will the Pharmacy list in the handbook be updated and by when?	The pharmacy list will be updated online as changes are made.
76.	LIHP Medical Policy Guidelines Psychiatric Services	Attachment G.4 If a primary care provider sees a patient for depression and bills a regular office visit (99213) does this count toward the 12 mental health visit cap per year? Or is this considered a medical visit based on the 99213 CPT code? How is the visit cap tracked? Please clarify process.	No, this would not be considered a specialty mental health visit, would not require a TAR, and would not count toward the cap of 12 visits. Specialty mental health visits require a TAR (except an urgent visit), and the cap is tracked by the ASO.

77.	LIHP Network Providers	Attachment F Not all providers and locations are listed. Can additional sites be added? What is the process to add sites?	If a current LIHP network provider or location is not listed, please let us know and we will add them. If a provider or location is not a current LIHP network provider or site, please refer to Section 14 of the LIHP Provider Handbook on how to become a network provider
78.	LIHP QM plan	Pg E.1 Please clarify that only clinics will collect this data. Hospitals will not all agree to provide this data but may allow the County to send someone in to audit medical records if the expense is reimbursed.	Clarification added. Please refer to updated LIHP Provider Handbook, Attachment E.
79.	LIHP QM Plan	Attachment E.1 Please clarify process for data collection and reporting for QM Plan components. Will the data be collected through chart review or electronic reporting? Are the data elements consistent with FQHC UDS report requirements?	Primary care clinics will report their QM data in an Excel file, which will be sent to the ASO. This data reporting tool will be distributed to clinics by the ASO. Each clinic site can gather their information electronically, through chart review, or a combination of both. Data elements are consistent with UDS, HEDIS, UM, ALL Heart and Beacon measures.
80.	LIHP QM Plan	Attachment E.1 Please clarify Mental Illness data sources and benchmark.	The ASO will be responsible for gathering data concerning the Mental Illness HEDIS measure. QI information will be shared quarterly with each clinic site.
81.	LIHP QM Plan	Attachment E.1 How much of the data will be gathered from clinics versus provided by ASO?	This will be clarified on the data reporting tool, which will be distributed to clinics by the ASO.
82.	LIHP QM Plan	Attachment E.1 Need to clarify < or > with several of the measures to ensure alignment with UDS and Meaningful Use (MU) measures.	Please refer to updated LIHP Provider Handbook, Attachment E.
83.	LIHP Requirements	How will the accountability piece work with	The ASO will monitor primary and specialty

	Monitoring	AmeriChoice? Who will monitor and how?	providers to adhere to LIHP requirements.
84.	Medical Home	a) What will be the process for assigning the Community Health Clinic as the Medical Home? b) Will Mental Health programs be informed of available capacity for each site?	a) The patient will select a Community Health Clinic as the Medical Home. This selection will be recorded on the POV site b) Please clarify this question. LIHP enrollees accessing mental health services are already assigned to a medical home, therefore we are unclear why capacity is being requested.
85.	Medical Home	Is it possible to assign patients to the organization rather than a clinic? This would reduce many billing issues for us.	No, patients will be assigned to a clinic site.
86.	Medical Home	Patients often switch sites to follow their physician, get urgent care, or get specialty services. It will be a big burden for us to explain these reasons through coding. Perhaps we could submit a report that shows the medical home assignment and who is accessing it to meet the County's goals?	No, patients will be assigned to a clinic site. Special coding will not be necessary for this, though the ASO will conduct audits to confirm clinic compliance with the policy.
87.	Medical Home	Can an LIHP beneficiary change medical homes?	Yes.
88.	Medical Home	If an enrollee with a medical need assigned to one clinic organization walks in the door to a clinic to which they are not assigned, can the clinic call the ASO, switch the patient's assigned site, and then see the patient.	No. It is up to the enrollee to decide whether they want to change medical homes and initiate the request. The enrollee must notify the ASO and select the provider. This information is included in the Enrollee Handbook.
89.	Mental Health – Services Cap	Why are there limits to LIHP/MCE Mental Health services and not to LIHP/MCE Physical Health services, in alignment with the Federal Parity Laws?	These limitations are per the Special Terms & Conditions between the Centers for Medicare and Medicaid Services and the State of California.
90.	Mental Health – Services Cap	Please clarify caps on mental health visits.	• Up to 12 Specialty Mental Health outpatient visits are covered each fiscal year for each enrollee. The clinic must submit a treatment authorization request (TAR) for these visits, and must receive approval.

			• Up to 10 Mental Health Inpatient days (acute days plus administrative days) are covered each fiscal year for each enrollee. • Primary care visits at a FQHC primary care site are not counted as a mental health specialty visit.
91.	Mental Health – Definition	What is the definition of "urgent"?	For Mental Health services the definition of urgent follow Title 9 • 1810.253 "Urgent Condition" means a situation experienced by a beneficiary that without timely intervention is highly likely to results in an immediate psychiatric condition." This mean that the person would be at risk for becoming a danger to self, or to others or gravely disability.
92.	Mental Health	Will the current definition for Mental Health Target Population be used by the ASO to determine where to send LIHP/MCE clients? Can there be a link in the LIHP/MCE amendment SOW, to the "Target Population" document for Contracted Mental Health clinics?	Please see Psychiatric Guidelines Attachment G
93.	Mental Health	Will the LIHP/MCE clients be included in the current mental health contracts unduplicated client minimums in the SOW?	No. LIHP/MCE clients will be in addition to current mental health contracts unduplicated client minimums in the SOW.
94.	Mental Health	It was noted that up to 1,000 current clients in County and Contracted Mental Health programs who are approved for LIHP/MCE benefits will be authorized for on-going mental health services through a "grandfathering" process. How will those 1,000 clients be allocated across all flagship programs?	There is no plan for allocation across all flagship programs. Each program should be checking their current client caseload and identifying those clients who appear to be qualified to receive the LIHP/MCE benefits. These clients will be given an opportunity to apply for LIHP/MCE. The goal to provide enrollment services to as many of these clients as possible prior to the end of September.
95.	Mental Health – Services	Are nurses able to provide MH services? Can RN visits be billed as a mental health	Nurses may provide MH services at non-FQHC locations as long as the mental health specialty is within their scope of practice and billed accordingly.

		specialty visit (1 of 12)?	
96.	Mental Health – Services	What happens if a client gets LIHP coverage after they have already received services?	Services that occurred within the previous 3 months may be covered by LIHP retroactively, if the client is otherwise eligible. Retroactive coverage cannot be approved for any month prior to 7/2011.
97.	Network Adequacy & Access Requirements	Page 11.1, Section 11 Hospitals will not be able to comply with some of the specialty access requirements. What does the 24/7 "medically necessary" service requirement apply to?	Network adequacy applies to primary care and specialist providers.
98.	Network Adequacy & Access Requirements	Page 11.1, Section 11 Accessibility to primary care services and specialty care access is a LIHP responsibility and is not a primary care provider responsibility. Should be reworded to identify responsibility or removed from Provider Handbook.	Meeting primary and specialty care access requirements is both a provider and a LIHP responsibility, and LIHP Special Terms and Conditions (STCs) require that these requirements are communicated to LIHP network providers. Primary and Specialty care clinic sites will be audited by the LIHP to ensure that appointment availability falls within the LIHP requirements.
99.	Network Adequacy & Access Requirements	Page 11.1, Section 11 Last bullet on service availability 24/7. This implies that primary care visits, labs, etc. are available 24/7. Please clarify.	Access to medical triage by licensed personnel from the primary care clinic site, specialty clinic, or their designee(s) must be available 24/7.
100.	Other Program Application Assistance	The clinic should not be held responsible for completing General Relief, State Disability or Social Security Disability paperwork- this is an unfunded mandate. We can certainly help with the health care requirements and steer patients to other places that can help. Our staff does not have the training for these other items.	This responsibility has been removed from the LIHP Provider Handbook.
101.	Patient Data from County/ASO	Can the County submit a list of LIHP enrollees to each clinic?	Yes. The process is under development.
102.	Patient Data from County/ASO	What reports will the clinics receive from the County/ASO regarding their patient population? How often? What format? What type of	This remains to be determined. The monthly and quarterly QI data reports that clinics are currently receiving will continue.

		reports? Enrollment reports? UM reports? Clinical outcomes reports? Pharmacy utilization reports? Hospital utilization reports? Specialty care reports?	
103.	PCMH Requirements – Intake Assessment	Page 15.1, Section 15 Primary Care Medical Home – An intake assessment of each new enrollee's general health status. Please provide example and clarify process. What is included in the intake assessment?	No new form is required. Clinics can use their existing health assessment tools.
104.	PCMH Requirements – Access and Continuity	Attachment A.1 Safety Net Connect or other Approved System Participation – Please clarify appointment access visit standards via system.	Please refer to updated LIHP Provider Handbook, Attachment A, Page A1.
105.	PCMH Requirements – Access and Continuity	Attachment A.1 Current Safety Net Connect system does not include all hospitals and clinic sites. System can't be fully utilized until more hospitals and clinics sites are added to the platform.	Please refer to updated LIHP Provider Handbook, Attachment A, Page A1.
106.	PCMH Requirements – Access and Continuity	Attachment A.1 After Hours Clinic Availability – Phase 2: PCMH NCQA Criteria. Please clarify. Too vague for clinics to commit to. Need more details.	Deleted from revised LIHP Provider Handbook.
107.	PCMH Requirements – Intake Assessment	Attachment A.2 Assessment for Health Risks – Behaviors – Interventions. Intake Assessment of each new patient's general health status. Please clarify	No new form will be required.
108.	PCMH Requirements – Reporting Requirements	Attachment A.3 Electronic registry/patient tracking for key conditions. Maintain electronic patient registry capturing defined patient data elements for key conditions. Provide current electronic report of patient status/outcomes to ASO quarterly. Please clarify data elements and reporting	Data elements for the QI measures will be reported on a quarterly basis to the ASO one month after the end of each quarter. Specific information for each QI data measure is listed in the QI attachment in the Provider Manual. Collection specifics will be delineated with the Excel collection tool that will be distributed to the primary care clinic sites by the

		requirements.	ASO.
109.	PCMH Requirements – Education	Attachment A.4 Patient/Family education on PCMH roles and participation. Please clarify education materials and process.	No new forms are required. Clinics can use their existing health education tools.
110.	PCMH Requirements – Reporting Requirements	Attachment A.4 Monitoring and Reporting on Access Standards. Submit access/audit reports from other programs. Need to clarify. Can clinics contractually submit access information from other payor sources? Can current CCHN access audit process and reporting meet this requirement?	This requirement has been removed from the provider handbook.
111.	PCMH Requirements – Reporting Requirements	Attachment A.4 ED/Hospital Utilization. Clinics do not have easy access to this data but the ASO does. Need to clarify clinic responsibilities and reporting requirements versus ASO responsibilities and reporting requirements. Add details or remove from Provider Handbook.	The ASO will work with the designated clinic coordinator to share data regarding transitions of care regarding individual enrollees. The ASO will communicate to the clinic's medical and operational leadership clinic-wide utilization data. The primary clinic site will be responsible for partnering with the ASO to improve utilization of services for individual clinic patients as well as for the clinic population as a whole.
112.	PCMH Requirements – Reporting Requirements	Attachment A.4 Clinical Outcomes for chronic disease management patients. Quarterly submission of registry reports. Please clarify. Need more definition.	Data elements for the QI measures will be reported on a quarterly basis to the ASO one month after the end of each quarter. Specific information for each QI data measure is listed in the QI attachment in the Provider Manual. Collections specifics will be delineated with the excel collection tool that will be distributed to the primary care clinic sites by the ASO.
113.	PCMH Requirements – Reporting Requirements	Attachment A.4 Selected Clinical Outcomes /HEDIS Measures. Maintain and report selected HEDIS measures quarterly. Need to clarify measures and	Data elements for the QI measures will be reported on a quarterly basis to the ASO one month after the end of each quarter. Specific information for each QI data measure is listed in the QI attachment in the

		process. Need more details on QM Committee and process to select measures. Clinics may not have easy access to all measures; may need to secure data on some measures from ASO. Need to clarify clinic responsibilities and reporting requirements versus ASO responsibilities and reporting requirements.	Provider Manual. Collections specifics will be delineated with the excel collection tool that will be distributed to the primary care clinic sites in July. The QM process is evolving and changes will be communicated from Dr. Tuteur through the primary care clinic medical director email list. The QI plan, which includes the list of reportable measures, will be created annually by the LIHP QM committee and presented for approval to the County.
114.	PCMH Requirements	Attachment A.4 There does not seem to be much information for MH clinics -- are they the first point of contact for an enrollee?	They can be, please see LIHP Provider Handbook.
115.	PCMH Requirements	I know there is a lot of excitement around the patient centered medical home. We support the effort and plan to seek certification. However, for the purposes of LIHP, I think it would reduce frustrations a lot if we could stop talking about the plans for 2013 until we have the details for the items we have to implement July 1.	Please see revised LIHP Provider Handbook, Attachment A.
116.	Preventive Care	Page 3.2 Section 3 Please clarify “Limited Preventative Medical Services”	Please see updated LIHP Medical Policy.
117.	Preventive Care	Breast and Cervical Cancer Screenings – Will patients be required to use CDP before LIHP?	Please see updated LIHP Provider manual. This is no longer a covered LIHP benefit, Attachment H.
118.	Preventive Care	Immunizations for Adults – Can we use County/State supplied vaccines or will we purchase and be reimbursed at cost?	State funded vaccines can continue to be used for LIHP following the same current guidelines/process.
119.	Preventive Care	Can you further define the mandatory preventative care benefits? We are assuming that Project Dulce level interventions are not required. Is this accurate?	Yes. Please see QI reporting requirements and the revised Preventive Care Policy in LIHP Provider Handbook.
120.	Primary Care Clinics	Page 4.1, Section 4	The enrollee may see <u>their</u> provider at any site

		Please clarify scenario for primary care services provided at a site other than the designated clinic site. Can you provide examples or scenarios of what will and will not be reimbursed?	within the parent clinic organization for a routine (scheduled) appointment or for an urgent visit. In addition, the enrollee may see <u>any</u> provider at any site within the parent organization for an urgent visit.
121.	Primary Care Clinics – Billing patients	Page 4.1, Section 4 Under CMS the patient is responsible for the physical exam ($75), under Section 4 (LIPH) states that the clinic is also responsible for completing the paperwork: we require further clarification on whether or not we can charge the patient for the non-reimbursable service (physical). The language is not clear and seems to require the clinic to absorb the physical exam.	Please refer to updated LIHP Provider Handbook, Section 13, Billing LIHP Enrollees.
122.	Prior Authorization	Page 3.2, Section 3 Will all laboratory services require prior authorization?	No. LIHP Provider Handbook has been revised to remove laboratory services from requiring prior authorization.
123.	Prior Authorization	Page 3.2, Section 3 Why is it that both Emergency Hospital Admissions and Acute Inpatient Services do not require prior authorization, and Acute Mental Health Hospitalization (up to 10 days) requires prior authorization (and is this even when it is an emergency admission)?	Please refer to updated LIHP Provider Handbook, Section 3, Covered Services.
124.	Prior Authorization	Page 10.1, Section 10 Please clarify the process of completing a separate form for test that will not be denied, and the requirement for clinics to notify the ASO of all primary care authorizations on a weekly basis. This is an unnecessary administrative burden – the primary care provider signature on the test request should be sufficient.	Please refer to updated LIHP Provider Handbook. The supplemental form has been eliminated.
125.	Prior Authorization	Page 10.1, Section 10 Cardiac tests in many clinic sites can't be done	Physicians may now order a treadmill cardiac stress test without needing to submit a TAR. The

		without a cardiology consult first. In this case, the cardiologist would generate the test request. Why create artificial barriers?	supplemental form has been eliminated.
126.	Prior Authorization	Pg 10.3, Section 10 H&P only is the standard with Optum Managed Medical and a minority of other plans.	Yes, this information is required for TAR submissions.
127.	Prior Authorization	Pg 10.3, Section 10 Hospitals request these edits: The ASO will provide each clinic of the status of their processed TARs electronically via eTAR on a daily basis. The referring **Primary Care Physician** or mental health provider **is** responsible for notifying the enrollee of the approved referral, **providing the enrollee with appropriate information to make** an appointment for the referred service, and forwarding appropriate medical information to the specialist.	No change, as the physician requesting the TAR is responsible for following through with the referral.
128.	Prior Authorization	Pg 10.3, Section 10 Who is eligible to request TAR or eTAR?	An eTAR must be signed by the requesting physician in the case of physical health referrals. At a mental health site, an eTAR may be signed by a licensed (not waived) mental health provider. Waived providers are able to order referrals without co-signature from licensed staff, since many are interns and their supervisor should be reviewing the referral.
129.	Prior Authorization	How will current clients who are approved for LIHP be given an authorization for MH services?	Providers will complete an eTAR request for current clients, and they will be approved for 12 outpatient visits. The eTAR mental health referral request includes 3 items that must be completed 1) client's diagnosis, 2) client's level of functioning, & 3) client's ability to improve with services.
130.	Prior Authorization	What will be the authorization process for new LIHP clients for Mental Health services?	Based on medical necessity the ASO will authorize 6 Outpatient visits for the first eTAR request, 3 for

			the second and, 2 for the third. Initial contact with a client for a complete behavioral health assessment will not require a prior authorization. If the eTAR system is not used and a referral is manually faxed, a mental health intake assessment form must be submitted with the manual TAR.
131.	Prior Authorization	How will the ASO know who can request an authorization?	Programs will need to notify the ASO of staff who will be requesting TARS. Programs will need to keep this list of staff updated and notify the ASO of new staff or staff that have left the program. The ASO will work with Providers to set up the system for informing them of staff names and future staff changes.
132.	Prior Authorization	If you cannot complete a request for an authorization through the eTAR process what process will be used?	If you cannot complete a request for an authorization through the eTAR process you will fax in the request. If you use the fax methodology you will need to send a copy of the evaluation/assessment along with the request. If the Fax process is used the provider should expect a response within 7-14 days.
133.	Prior Authorization	How will we get the authorization number?	The authorization number will come back to the provider via eTAR or letter if provider has used the fax process. The provider should include the information about which programs is requesting the TAR so that the correct programs will receive the authorization.
134.	Prior Authorization	What time period will the mental health authorization cover?	The mental health authorizations will be good for the FY (July 1-June 30). For example, if a client receives an authorization for 6 services on May 1, the authorization will expire on June 30, the end of the fiscal year. New authorization will be required the beginning of the next FY, since authorized visits may not be carried over from one FY to the next.
135	Prior Authorization	Will the time spent filling out the eTAR be	No. The time spent filling out the eTAR is non-

		billable as part of the service?	billable time.
136.	Prior Authorization	Will the ASO be communicating with providers as to the status of authorized services, for example letting providers know when authorizations are about to run out?	The providers will have to track the number of services used and request a new TAR when the services left on the authorization are running out.
137.	Prior Authorization	What happens if a service is provided to a client and the client's' authorized services have been used?	For the County and Contracted Mental Health Programs if the service is medically necessary the service should be tracked as a non-LIHP service and will be covered in the regular claiming process for indigent care.
138.	Prior Authorization – Medication	As far as medications for LIHP/MCE clients it looks like generics and PAP are only options. What if client can't use a generic and there is no PAP, or PAP is denied- what are other options? Prior authorization request. All current CMS meds are on the formulary	If PAP is denied, please submit a prior authorization request to ASO. The other options for medications for LIHP/MCE clients are to use samples or identify other medication options.
139.	Prior Authorization – Medication	Can a provider move client from LIHP/MCE program before an authorization ends? (For instance, if a client needed a brand name med and MCE won't cover)	No
140.	Provider Credentialing	Page 13.3, Section 13 Credentialing – Clinics have a current credentialing process through PPMC and CCHN. Can this process be used to meet LIHP credentialing requirements?	No. Credentialing must be done through the ASO for all providers, physical health and mental health. Discussions with the CCHN are underway to avoid duplication of credentialing efforts.
141.	Provider Licensing Requirements	Can psych assistants and MFTs who are still working on their licensure but don't have it yet see patients and bill LIHP?	No, they are not licensed therefore they cannot bill. All LIHP enrollees must have a face to face meeting with a licensed or waivered clinician in order for the clinician to bill LIHP for this visit.
142.	Provider On-Line Verification	When completing the form for the Provider On-Line Verification (POV) what number will be used as the ID#?	The Provider ID # is the provider's tax ID #. The enrollee's ID# is a random unique number assigned to them and is listed on their member card.
143.	Quality and Utilization	Attachment C.1	This will be done by the ASO through a private

	Management	Identification, Risk Stratification and Health Risk Assessment. Please clarify predictive modeling and care management models to risk stratify enrollees.	United Healthcare product.
144.	Rates	What is the process to document and communicate the following to the County/ASO – current PPS rates, PPS rate change (retroactive implications), changes to PPS rate due to triggering events (retroactive) and MEI annual increases to PPS rate?	During the terms of the LIHP contract if there is a change in the providers PPS rate please follow procedures identified in LIHP Exhibit C-7. Clinics will need to provide verification of any change to their current PPS rate within 10 days of notification in order for their current LIHP rate to be changed.
145.	Rates	Should pharmacy rates be included in this contract or is that a separate contract for those clinics that provide pharmacy? It was a separate contract under CI. Some clinics include pharmacy costs in their PPS rate and some do not. How will this be handled?	LIHP will cover pharmacy costs at participating pharmacies.
146.	Rates	The MCE group rate listed: does the Contractor need to divide that per attendee of the group?	Please clarify the question.
147.	Rates	Will the County retroactively adjust for PPS rate increases?	No. The County will pay the FQHC clinic's PPS rate that is in effect at the time the clinic service occurs.
148.	Satisfaction Survey	Patient satisfaction surveys- mentioned on a.4, section 6b- are our existing patient satisfaction surveys sufficient (will differ by clinic organization)? Can we submit results rather than actual surveys?	The ASO conducts these surveys.
149.	Scope of Practice	One page 3.3 under second opinion- what do you mean by "Conservative therapy has not been attempted…"	Community standards of primary care scope of practice.
150.	Second Opinion	Page 1.1, Section 1 Out-of-network second opinions must receive prior approval. Will clinics need to get prior authorization for all mental health services if the clinic is not a current mental health contractor?	Out-of-network mental health services are not a covered benefit of LIHP. If a mental health clinic is not a LIHP contractor, they are not authorized to see LIHP enrollees, and a Treatment Authorization Request (TAR) should not be submitted.

151.	Second opinion	Pg 3.3 Section 3 What if the enrollee disagrees with the diagnosis (Mental Health)	Enrollee may request a second opinion if they disagree with diagnosis.
152.	Services – Outpatient	Page 3.2 Section 3 What about observation status patients not admitted but needing acute hospital care (e.g. chest pain, rule out MI)?	Observation status (hospital admission for less than 24 hours) is not a covered benefit of LIHP. Revised language will be added to the next LIHP Provider Handbook revision.
153.	Telehealth/Telemedicine Services	Are telehealth and telemedicine services included under LIHP? Telepsychiatry? E-Consults to reduce demand or specialty care services?	The County's application to the state includes telemedicine and electronic consultations, pending final approval from the State.
154.	Training	Will the training be recorded and archived so the content and the Q & A can be accessed at a later date?	No, however this FAQ will be available in the future.
155.	Training	FHCSD is interested in hosting on site LIHP enrollment classes and can offer space at many of our sites; can we coordinate this with you?	Please clarify this item, we are unclear what "enrollment classes" entails.
156.	Contracts	Contracts should include a minimum implementation date for any Phase II work, with the ability for clinics to opt out of the program at that time. Leaving the timeframe for implementation puts clinics in a position of signing a contract without full information on what will be required.	Please see revised Provider Manual. References to Phase II have been removed.
157.	Contracts	Should the Total Contract Price be listed on the MCE amendment page?	Yes. Total Contract Price will be listed on the MCE amendment page
158.	Contracts	The Mental Health RFP's scheduled to occur in FY 11-12 for new contracts beginning in FY 12-13: can those be re-scheduled for a later date so time can be spent to ensure MCE project is successful, rather than on writing proposals? (Is it possible to get additional authority for those expiring contracts?)	To be determined by Adult and Older Adult System of Care
159.	Contracts	Has it been confirmed that this is a FFS cost	Please clarify this question.

		reporting method?	
160.	Contracts	How will Contractors be able to allocate staffing time spent across LIHP/MCE and non-LIHP/MCE clients? How will the separate reimbursement from the ASO for this project affect the Contractor's cost allocation and indirect rate claiming and related fiscal items?	FQHC clinics should follow the instructions on the State form # DHS 3090, *MEDI-CAL COST REPORT INSTRUCTIONS FOR PROSPECTIVE PAYMENT SYSTEM.* Any further questions on this issue should be referred to your State contact for this report or to your accountant. The County cannot advise on issues that affect an individual clinic's financial records.
161.	Contracts	Exhibit A-7: Statement of Work 5.1Contractor shall identify one care coordinator contact between the Administrative Services Organization and each clinic site. We need further clarification as to what this individual will do. Also, we are assuming it can be an existing individual, such as a Site Manager who has other duties? Please clarify.	The care coordinator will be the point of contact with the ASO. This can be an individual with other duties.
162.	Contracts	Exhibit C-7: Payment Schedule What is the process to identify current PPS rates by site to include in Exhibit C-7?	As identified in Exhibit C-7, clinics have been requested to provide official supporting documentation of their PPS rate and the services covered under that PPS rate.
163.	Contracts	Exhibit C-7: Payment Schedule As PPS rates change, what is the process for clinics to update Exhibit C-7 with their new PPS rate(s)?	Send documentation within 10 days of the change.
164.	Contracts	Exhibit C-7: Payment Schedule What is the process for the ASO to pay the clinic retroactively based on changes to PPS rates by clinic site?	The County will pay the FQHC clinic's PPS rate that is used by the clinic at the time of service. Any adjustments will only be from the date of the PPS rate change forward; no retroactive adjustments will be made.
165.	Contracts	Section 1.3 – Contractor will submit invoices detailing the PPS payment amount – we are not sure what this means? Do they mean they will submit a claim with the charge equal to the PPS	Please refer to Section 13 of the LIHP Provider Handbook for information regarding submission of claims.

		rate? It doesn't make sense that we would have to complete an invoice for each visit. Please clarify.	
166.	Contracts	The current clinic contract includes CMS Diabetes Case Management Services in Exhibits A-4 (scope) and C-4 (payment). Can you please clarify if these services are continuing? If not, is there new contract language to reflect the change?	For those contracts that include the Whittier Institute, the scope will continue without a contractual requirement to collaborate with the Whittier Institute.
167.	Contracts	A-7 Section 2 Section 2.2 references "The following CMS Exhibits also apply to LIHP" but these (A-5 and C-5) are CI references, not CMS. It would be cleaner to include these provisions in LIHP Exhibit A-7. Sections 2.2.1 and 2.2.2 reference that certain CI provisions, A-5 (Quality Assurance and Utilization review) and C-5 (Third Party Payer and Medi-Cal Eligibility), shall remain in full force and effect but they have been deleted with this Amendment (as part of CI). As previously noted, the County should re-write the LIHP amendment to include these provisions A-7 and C-7.	Correction will be made to these references.
168.	Contracts	Exhibit A-7 Section 7 Section 7.1 reads that clinic "shall provide services at the site(s) listed in Attachment A". Should the sites listed in Attachment A include PCMH sites, mental health only sites and dental only sites? Section 7.2 reads clinic "shall provide clinic hours of operation at each site listed in 7.1 for a minimum of 35 hours per week unless exception	Attachment A should include only those clinic sites that have been added to the contract. Submit written request/notification to: Contracts Manager 8840 Complex Drive, Ste 255

		approved in writing by COUNTY". What is the process to seek written exception approval by the county if so? Section 7.3: County requires 90 days advance notice of any change to changes in hours of operation. Can this be changed to 30 calendar days? Section 7.4: County requires 90 days advance notice to term a site or change the location of a site. Is this realistic? County may need this much time to notify patients.	San Diego, CA 92123-1423 Not at this time but will consider if any reduction can be made to the 90-day advance notice. The 90-day advance notice rule has been in effect since the beginning of these contracts and further study is necessary to reduce the number of days.
169.	Contracts	Exhibit C-7 Section 1.4 reads "Clients must be enrolled at Contractor's clinic as the client's PCMH in order for clinic to receive reimbursement." We heard from the county on 6/21 that patients can access care at the following un-assigned clinic sites within the same clinic tax ID as described in the LIHP handbook. Is that accurate? Are the following exceptions noted in this Section as well? • Urgent care • If their PCP is at multiple sites • If the clinic has a central disease management site • Access to specialty visits Please clarify the billing guidelines and processes to identify these claims and to educate clinics on how to bill.	Yes, accurate. Please see handbook.
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170.	Care Coordinator Designation	For the care coordinator staff function, can you provide more details on a job description or the scope of activities for that person?	A point of contact at each site of primary care and specialty clinics, including mental health, who is available by phone, fax and email. This person would receive communication from other clinicians or the ASO regarding quality or utilization issues concerning an enrollee being seen at (or assigned to) that site. The care coordinator would be expected to have access to the health records of that patient, demographic information (ie, updated phone and address), and be able to communicate messages to the treating clinician and flag the chart in a timely manner.
171.	Eligibility/Enrollment	• How is the CMS population going to convert to LIHP? • Is there still a lien requirement under CMS?	• CMS beneficiaries will be evaluated for LIHP when they apply to renew their coverage. • Yes, there is a lien requirement in CMS.
172.	Formulary/Pharmacy	When our patients go from the CMS program to the Low Income Health Program, aren't they really becoming enrolled in LIHP (a coverage program), so the PAPs might not cover them if they now have coverage?	LIHP is not an insurance, and some pharmacologic agents are not included in the LIHP formulary. In these cases, enrollees may be eligible to receive medications through a PAP. If the enrollee is denied enrollment in a PAP, then the prescribing provider may submit a PA request to the ASO.
173.	Hospital Based Services	Please clarify what exactly is expected in a discharge summary?	The County recognizes there are documentation differences between facilities; therefore your facility's current discharge summary should suffice.
174.	LIHP Network Providers	Can the clinics get a list of the lab, pharmacy and radiology that the ASO contracts with? If they do not provide these services in-house, they want to make sure they are referring their patients to the right place.	A listing of LIHP Network Pharmacies is in Attachment F of the LIHP Provider Handbook. For all other specialties, changes occur frequently. If they have questions, providers may call the ASO's Medical Management Department to ensure the most current information is provided to the LIHP enrollee.
175.	LIHP Psychiatry Policy	Please clarify the "screening" initial exam in the LIHP Psychiatry Policy.	A "screening" initial exam that is reimbursed without prior auth must include a "behavioral health

			assessment" and is not just a triage or quick screen.
176.	Mental Health	If an enrollee hasn't used all of their 12 Mental Health Specialty visits from the previous FY, can these "roll over" into the next fiscal year?	Mental health specialty encounters from the previous fiscal year do not roll-over to the new fiscal year.
177.	Mental Health	Group psychosocial rehab and Individual psychosocial rehab are listen on Section 15 of the Provider Manual as NOT reimbursable by a CPT code, but reimbursable by a HCPCS code. I thought this means that the CMH or contracted CMH folks can bill LIHP for group or individual rehab, but the FQHC mental health clinic cannot. Please provide clarification.	CMH (County mental health), contracted mental health providers and FQHC mental health providers can bill for group and individual psychosocial rehab if it is within their scope of practice.
178.	Mental Health	If a LIHP enrollee uses their 12 outpatient visit benefit before the end of the fiscal year, do they remain eligible for psychiatric meds, and all meds, under LIHP?	If the patient is still a LIHP enrollee, upon reaching the 12 outpatient visit maximum, services switch over to County Mental Health. The pharmacy benefits for all medications (including psychiatric meds) will continue to be provided to the enrollee through LIHP.
179.	Preventive Care	Can you clarify if any pap or mammo preventives services are included under LIHP?	No screening pap or mammo services are covered by LIHP. Please see the Preventive Services Policy in the LIHP Medical Policies.
180.	Provider Credentialing	Please provide clarification of how to get mental health providers credentialed or waivered under LIHP.	• If a MH provider is licensed (MD-psychiatrist, PhD- psychologist, MFT, or Social Work are the only licensed staff) then they must be credentialed through the ASO. • If the MH provider is not-licensed (ie, has their degree but still an intern and not yet licensed) AND is working in a clinic that provides Short-Doyle Medi-Cal with other Licensed MH providers, then they must submit an application to the County of San Diego Behavioral Health Services Quality Improvement Department, who will submit it to the State for adjudication as a waivered clinician.

			• Non-licensed staff may not be waivered if they are not in the office with other licensed staff to supervise them.
181.	Provider On-Line Verification	In the POV system, will the clinics we able to identify the site that the patient is assigned to?	Yes
182.	Specialty Referral	If a clinic refers a LIHP patient to their own gyn for gynecological problems (like excessive bleeding, not preventive care), it that ok? We are assuming that screening pap smears are not ok, right?	It is at the clinic's discretion whether to refer to their own gynecology department. A TAR is required to be submitted and approved in order to bill for specialty services, including Gynecology. Screening pap and mammogram services are not covered benefits of LIHP (please see Preventive Services Guidelines attached to the Provider Handbook).
9/2/11 Release			
183.	Billing	Can you define what services we can directly bill for and what you are proposing we provide as part of the PPS rate?	The PPS rate includes all LIHP covered services linked to a face to face encounter with an approved clinician. Note: Lab, radiology and pharmacy services not provided at the FQHC will be billed separately by the provider of these "carve-out" services.
184.	Billing	Can an enrollee have 2 visits in the same day at the same community clinic organization (e.g. PCP visit and mental health visit)?	Yes. Services provided during an enrollee's visit should be within the individual's scope of practice and billed according to PPS regulations.
185.	Billing – Mental Health	Currently we have some MFT services included in our PPS rate. If we hire new staff, could we bill their services to LIHP via the FFS rate? (We don't have a mechanism for trigger a scope change to get the added cost of their salaries in our rate.)	No, cannot bill FFS fee schedule. All licensed, registered and waivered mental health clinicians who provide care at a FQHC can provide mental health specialty visits and bill as such (after receiving TAR approval). The FQHC's would bill these services according to their PPS rate within that clinic site.
186.	Billing - Mental Health	For the county and contracted mental health programs, if an assessment by a mental health clinician, a medication service by psychiatrist, and medication support service provided by a	Yes, these are 3 separate encounters and would be paid at a FFS rate.

		nurse are all delivered on the same day is this counted as 3 separate encounters? Would all 3 services need to be authorized? And if so, how would we get authorization for the services if they are all provided on the same day and it is the client's first contact with the programs?	Yes, all three services would need to be authorized. Urgent same day appointments can be authorized through the retro authorization process with the ASO.
187.	Billing - Mental Health	Can licensed, waived credentialed mental health providers see enrollees at a PCP (not a mental health specialty) site? If so, do those visits count as 1 of 12 outpatient mental health visits? Or can they be billed as a PCP visit at the site's PPS rate?	Yes. All physical health and mental health services should be billed according to FQHC guidelines. Any LIHP covered mental health services at a FQHC count towards the 12 Specialty mental health visits which require a TAR and is paid at the clinic site's PPS rate. If the mental health service is provided by the PCP, this does not count toward the 12 outpatient special mental health visits and is billed as primary care visit at the clinic site's PPS rate.
188.	Claims	Page 13.2, Section 13 Primary Care Clinic (FQHC) – Services not included in the Clinic's PPS rate to LIHP enrollees will be paid at FFS reimbursement schedule available from the ASO, assuming the services are covered benefits of LIHP and prior authorization was obtained as appropriate. Please provide examples and clarify process.	The Handbook has been revised. Any LIHP covered physical health service will be billed via the ASO and paid at the clinic's PPS rate. Any ancillary services provided outside of FQHC will be reimbursed at a FFS fee schedule to the ancillary provider.
189.	Contracts	Exhibit C-7: Payment Schedule Section 1.2 – What is the process for clinics to submit PPS rate information from verified cost reports to include in Exhibit C-7?	FQHCs should submit the Medi-Cal Remittance Advice (RA) Summary and detail by clinic site. Submit verification for the PPS rates to: Contracts Manager

			8840 Complex Drive, Ste 255 San Diego, CA 92123-1423
190.	Mental Health - Services	Will licensed, registered and waivered staff be allowed to bill for Mental Health services for LIHP beneficiaries?	At the FQHCs, county and contracted mental health programs licensed and registered waivered clinicians will be able to bill for LIHP services. Specifically, MFTs may bill for services at the FQHCs and qualified RNs may bill for services at the county and contracted mental health programs. All licensed clinicians must be credentialed through the ASO. All registered waivered clinicians must submit their state letter of registered waivered status to the ASO.
191.	Mental Health – Authorization	Who needs to request the TAR?	A licensed clinician (MD, PhD, PsyD, MFT, LCSW) must initiate the TAR. However, the eTAR can be sent to the ASO by designated, non-clinical program staff.
192.	Mental Health – Pharmacy	Will the County Pharmacy be able to fill MH prescriptions?	Not at this time. Any pharmacy may apply to become a contracted LIHP pharmacy.
193.	Mental Health – Pharmacy	Will clients need to have an ID to pick up their prescriptions?	Yes.
194.	Mental Health – Pharmacy	Will there be any co-pay for MH medications?	No.
195.	Mental Health – Services	Will triage/screening be a billable service?	No. Triage or screening will not be billable to LIHP. Billable assessments must be the complete Behavioral Health Assessment.
196.	Mental Health – Services	How will county and contracted MH programs be able to refer a client to Primary Care when appropriate?	By completing the eTAR form and noting that this client is referred to primary care under the section “Suggested Refer To”.
197.	Mental Health – Services	What happens if a client does not meet criteria for services but still needs some mental health services?	If the client does not meet the LIHP criteria for specialty mental services required on the eTAR form, the clinician can choose to see the client under other programs available for indigent mental

			health services.
198.	Mental Health – Services	When checking the POV will staff need to enter the TIN# every time?	Yes.
199.	Mental Health – Services	How will the program be able to designate that a client is a current client on the eTAR form so that they can get the grandfathered auth for 12 services?	The ASO will inform programs how to do this on the eTAR form.
200.	Mental Health – Services	What types of services will be authorized within the first 6 authorizations, and the follow up authorizations?	The ASO does not limit or designate the types of services. Instead, the ASO authorizes a certain number of services. The clinician is responsible for determining the type and combination of services that best meet the needs of the client, within the approved types of services covered by LIHP.
201.	Mental Health – Inpatient Services	How will History and Physicals (H&P) be covered for MH patients?	H&P will be covered under the physical health benefits.
202.	Mental Health – Inpatient Services	Will all psychiatrists be LIHP providers?	Initially, Optum will offer a LIHP addendum to psychiatrists who have a contract with Optum at the corporate level and privileges at the participating hospitals. Optum will notify the hospitals regarding which of their psychiatrists are in that category and will be offered the addendum. If there is a service provided by a non-contracted LIHP psychiatrist, or by a hospital that has no psychiatrists with a corporate contract, Optum can do a single case contract. Please contact Harriet Stupp at 619-641-6832 with questions about contracting for inpatient psychiatrists.
203.	Mental Health – Due Process	How will Optum handle denials and appeals?	OptumHealth will be handling denials by issuing Notices of Action (NOAs). The denial process will be similar to the denial process used for Medi-Cal beneficiaries. The appeals process will be managed by the ASO, AmeriChoice. The denial process will also be very similar to the current Med-Cal process, including options for retrospective

			review and expedited appeals.
204.	Mental Health	Can a mental health trainee see and bill for a client when their supervisor co-signs their work, but doesn't actually meet 1:1 with the client? (the trainees are non-licensed, non-waivered,/credentialed persons in-training for their LCSW, MFT, PhD, or PsyD degree.)	No, they are not licensed therefore they cannot bill. All LIHP enrollees must have a face to face meeting with a licensed or waivered clinician in order for the clinician to bill LIHP for this visit. A licensed staff may NOT merely sign-off on trainee's note without seeing the patient.
205.	Mental Health	Can a RN and/or LVN see and bill for a mental health client?	ASO credentials licensed individuals who provide LIHP services, therefore RN and/or LVN can see and bill for a mental health client within their scope of practice.
206.	Primary Care Clinics Contracts	If a FQHC has a primary care contract; is a separate unique contract required for specialty services within that same FQHC (same address)?	If a FQHC has a primary care contract, all specialty care services provided within that site does NOT require a separate unique contract for specialty services.
207.	Primary Care Clinics – Simple Procedures	Page 4.1, Section 4 Simple procedures. Need more details, definitions on what injectables should be part of primary care visit (e.g. antibiotics, anti-TNF alpha meds, vaccines). Need to address billing issues, especially injectables and vaccines, which should not be part of primary care visit and should be billed separately.	All LIHP covered services provided at the FQHC will be reimbursed at the PPS rate following PPS billing policies.
208.	Primary Care Clinics – Prior Auth	Page 4.2, Section 4 Diagnostic laboratory tests. What needs prior authorization?	Please defer to the LIHP Medical Policies (links are noted on page 1 of the FAQs).
209.	Primary Care Clinics	Page 4.2, Section 4 Plain radiographs (2 view films). Who is responsible for films? Not included in most clinic FQHC rates. Currently included in CMS and CI (billed directly to imaging center). Please clarify	LIHP ancillary covered services provided during the enrollees visit at the FQHC will be paid at the FQHC's PPS rate as part of the enrollee's visit with PCP. Ancillary services not provided within the FQHC, will be billed by the ancillary provider.
210.	Rates	How will you determine what is in vs. not in our rate? Can we schedule a meeting to discuss?	The PPS rate includes those services which the FQHC included when calculating and submitting their PPS rate, and as it was approved by the

			federal government. It is not the place of the LIHP to determine what is in or excluded from each FQHC's PPS rate.
9/19/11 Conference call			
1	Does a client need to be in a mental health program to be approved for LIHP?		No.
2	Can they use the medical services that LIHP provides?		Anyone approved for LIHP can access all services LIHP provides.
3	If we have a situation where a parent does not have their children in the home, for whatever reason, why does LIHP send them to apply for Medi-Cal , when Medi-Cal will deny them?		We do not require all LIHP applicants to apply for Medi-Cal first, however all applicants are screened for Medi-Cal. If potential linkage to Medi-Cal is identified, then the applicant would be required to apply for Medi-Cal.
4	Our client has already been denied Medi-Cal, what should they do now?		They should go to the nearest FRC and apply for LIHP.
5	E-TAR for mental health. User name & password were entered, a client's name and SSN popped up, and the user could not get out of the screen to enter another client's information.		Please contact the ASO and they can assist you with the E-TAR process.
6	What information are we putting out there regarding the FRCs?		We have updated the flier posted on San Diego's LIHP website. We are also revising the Provider and Enrollee handbooks, as well as the LIHP Notices of Action.
7	Will we be notifying those with a pending eligibility appointment that they can now walk into an FRC to apply?		We are working with the ASO to determine if this can be done.
8	Indian Health Council is not listed in the Provider Handbook because they serve a specific population (not open to the general public). Since they aren't listed, their clients cannot select them as a medical home, therefore Indian Health Council cannot be reimbursed for the services they provide. How can this be resolved?		We will research this issue.
9	(from the 9/15/11 Stakholder meeting) Can the County allow presumptive eligibility for CI/LIHP enrollees so they won't have a lapse in eligibility due to their recert not being processed since the STCs allow for it?		We researched the STCs and could not find any language permitting presumptive eligibility.

Summary of LIHP Questions and Answers